Buckland Ear, Nose & Throat, LLC

Medical History

Patient Name:_____ Today's Date:_____

Primary Care Provider: _____ Referred by: _____

Pharmacy You Use: _____ Date of Birth: _____ Age: _____
Name City

1. Reason for visit:_____

2. Past Medical History: (Check all that apply)

__ high blood pressure	__ hepatitis/ A,B or C	__ depression
__ heart disease	__ liver disease	__ anxiety
__ chest pain	__ kidney disease	__ psychiatric illness
__ irregular heart beat	__ cancer	__ drug addiction
__ rheumatic heart disease	__ tuberculosis	__ alcohol problem
__ diabetes	__ asthma	__ reflux/GERD
__ bleeding disorders	__ bronchitis, emphysema	__ hay fever
__ stroke	__ shortness of breath	__ food allergies
__ seizures	__ enlarged lymph nodes	__ blood disorder
__ thyroid problems	(neck, under arm, groin)	__ sleep apnea
__ aids/HIV	__ vertigo	__ high cholesterol
__ immune disorders	__ hearing loss	__ arthritis

__ other _____

3. Medication allergies: (name of drug and reactions)

4. Do you smoke? Yes / No. _____ packs per day for _____ years.
   If not, have you ever smoked? Yes / No. _____packs per day for _____ years. I quit _____ years ago.

5. Do you have a history of alcohol use? Yes / No How much?_____

6. Previous surgery: Type Year
   Ear, nose or throat:
   Other:

7. Have you had any adverse reactions to surgery or anesthesia? Yes / No

8. Family history of (circle all that apply):
   diabetes heart disease cancer bleeding tendencies reaction to anesthesia

9. Are you pregnant? Yes / No

10. Have you had previous allergy testing? Yes / No

MEDICATION LIST

DATE: _____

NAME: _____DATE OF BIRTH: _____

NAME	STRENGTH	DOSAGE
INCLUDE OVER THE COUNTER AND HERBAL MEDICATIONS		
Example: Calcium	**600 mg**	**one tablet 3 times a day**
***DO YOU TAKE ALL YOUR MEDICATIONS BY MOUTH? YES____NO____**		

Buckland Ear, Nose &Throat, L.L.C..
Michael J. Franklin, M.D.
Vanessa Romero, MS, PA-C

PLEASE FILL OUT ALL INFORMATION REQUESTED

PATIENT'S NAME: _____ SOC. SEC. NO: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME: ( ) _____WORK: ( ) _____ CELL: ( ) _____

DATE OF BIRTH: _____ SEX: ___M ___F MARITAL STATUS: M___ S___ W___ D___

EMAIL ADDRESS: _____PRIMARY CARE PHYSICIAN: _____
NAME CITY

EMERGENCY CONTACT: _____
NAME ADDRESS PHONE RELATION

EMPLOYER: _____
NAME CITY

IF PATIENT IS A CHILD:

FATHER'S NAME: _____ MOTHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE NUMBER: H)_____C)_____ PHONE NO: H)_____C)_____

EMPLOYER: _____ EMPLOYER: _____
NAME PHONE NO. NAME PHONE NO.

HIPAA RELEASE: I AUTHORIZE RELEASE OF MY HEALTH INFORMATION TO: (i.e. spouse, children, physicians, other)

NAME(S): _____ _____ _____

PRIMARY INSURANCE

INS CO. NAME: _____

SUBSCRIBER'S NAME: _____

PT.'S RELATION TO SUBSCRIBER: _____

SUBSCRIBER'S SOC. SEC. NO: _____

SUBSCRIBER'S DATE OF BIRTH: _____

INS. ID NO: _____

GROUP NUMBER:_____

EMPLOYER: _____

SECONDARY INSURANCE

INS. CO. NAME: _____

SUBSCRIBER'S NAME: _____

PT.'S RELATION TO SUBSCRIBER: _____

SUBSCRIBER'S SOC. SEC. NO: _____

SUBSCRIBER'S DATE OF BIRTH: _____

INS. ID. NO: _____

GROUP NUMBER: _____

EMPLOYER: _____

DO YOU HAVE A THIRD INSURANCE: YES___ NO ___ IF YES, PLEASE LIST ON BACK OF THIS FORM

HOW DID YOU HEAR ABOUT US: YOUR PHYSICIAN___ OUR WEBSITE ___ YELLOW PAGES ___ OPG.COM ___ OTHER _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Buckland ENT for services rendered. I understand that I am financially responsible to the doctor for charges not covered by this assignment. I also understand even though I have insurance coverage, I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Today's Date: _____Patient's or Other Authorized Signature: _____

BUCKLAND EAR, NOSE, & THROAT, LLC

Michael J. Franklin, M.D., D.D.S. Vanessa Romero, PA-C

PAYMENT POLICY

If you do not have insurance, payment will be expected on the day the service is provided.

If you arrive for your appointment without your insurance card, you may be asked to reschedule your appointment.

All co-payments must be paid when checking in with the receptionist.

As a courtesy to our patients, we will file an insurance claim for service provided only if you have provided us with **complete and correct subscriber insurance information** and that you have **signed the authorization section on your Patient Information Sheet.**

If you belong to a managed care insurance plan, you signed a contract that does not allow you to see a specialist without prior approval from your primary care physician (PCP). **You are responsible for obtaining this referral from your PCP.** If we do not have a documented referral from your primary care physician's office prior to your appointment, your visit **will not be covered by your insurance and you will be responsible for the payment on that date of service or your appointment can be rescheduled until the referral is obtained.** These are the guidelines set up by your insurance company and stated in your Insurance Policy Manual.

Within 30 days, you will receive a statement of your account. It will show the total amount due by your insurance and amount due by you. We will expect full payment on your account within 45 days of the date of service. If payment has not been received by that time, you will receive a **PAST DUE** letter as a warning. If payment is not made within 60 days, we will take further **collection action**.

In the event there is a duplicate payment on your account and it shows a credit balance, we will refund the amount immediately.

All checks returned for non-sufficient funds will be subject to a $20.00 additional charge.

If you have any questions, please feel free to call the office. We will be glad to help you anyway we can.

LATE FOR APPOINTMENT/NO SHOW POLICY

Buckland Ear, Nose, and Throat reserves the right to reschedule your appointment if you are 15 or more minutes late.

Buckland Ear, Nose, and Throat reserves the right to charge $25.00 or $100.00 (depending on appointment type) for appointments missed by the patient without a 24 hour notice of cancellation.

After two missed appointments without prior notification, your will receive a letter requesting you to find another physician.

****I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Date: _____ **Signature:** _____

Patient or Responsible Party

Acknowledgment of Receipt of Notice of Privacy Practices

Buckland Ear, Nose, and Throat, LLC
360 Tolland Tnpk., Suite 1E
Manchester, CT 06042

Privacy Officer
860-645-6675

Name of Patient: _____

I hereby acknowledge that I understand this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appiontment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

For Office Use Only:

- Signed form received by: _____
- Acknowledgment refused:

  Efforts to obtain:

  _____

  _____

  Reasons for refusal:

  _____

  _____